Received:

## IMPORTANT: Tests performed will be determined on the basis of information provided below.

## Reported:

## VIRUS **EXAMINATIONS**

## State of Washington Department of Health

DIVISION OF PUBLIC HEALTH LABORATORIES 1610 NE 150TH St MS: K17-9 Shoreline, Washington 98155 Ph (206) 418-5458 FAX (206) 418-5485

Lab.	No.				

Please Use Black Ink

Patient	ast name)			(first) Age Se	
•				City	Blood/Serum CSF
Date Spec. (				Date Onset	
mmunizatio					Stool
Chief Clinica	l Findinas	(check s	svstem invo	olved and list chief symptoms)	
	-	•	•		
				nd Type	
) Gastro	ointestinal				_
) Cardio	vascular				
					2331553331503353315311531531531531531531531531531531
Clinical Imp					_
Optimally, co	llect isola	tion speci	imen within	3 days of onset. Submit eac	h specimen as soon as
County	e/Phone _	-(		(zip code)	signature of physician
County	e/Phone _		) — (DO N	(zip code)	IE) <del></del>
County	e/Phone _		) — (DO N	(zip code)	
County	e/Phone _		) — (DO N	(zip code)OT WRITE BELOW THIS LIN	IE) <del></del>
Countyaboratory R	e/Phone _	C TESTS	— (DO N	(zip code)OT WRITE BELOW THIS LIN	IE)
County	e/Phone _	C TESTS	— (DO N	(zip code)OT WRITE BELOW THIS LIN	IE)
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County	e/Phone _	C TESTS	— (DO N	(zip code)OT WRITE BELOW THIS LIN	S ISOLATION at and Result
aboratory R SE Antigen	e/Phone _	C TESTS	— (DO N	(zip code)OT WRITE BELOW THIS LIN	IE)